

Medical Claims Filing for Dentists

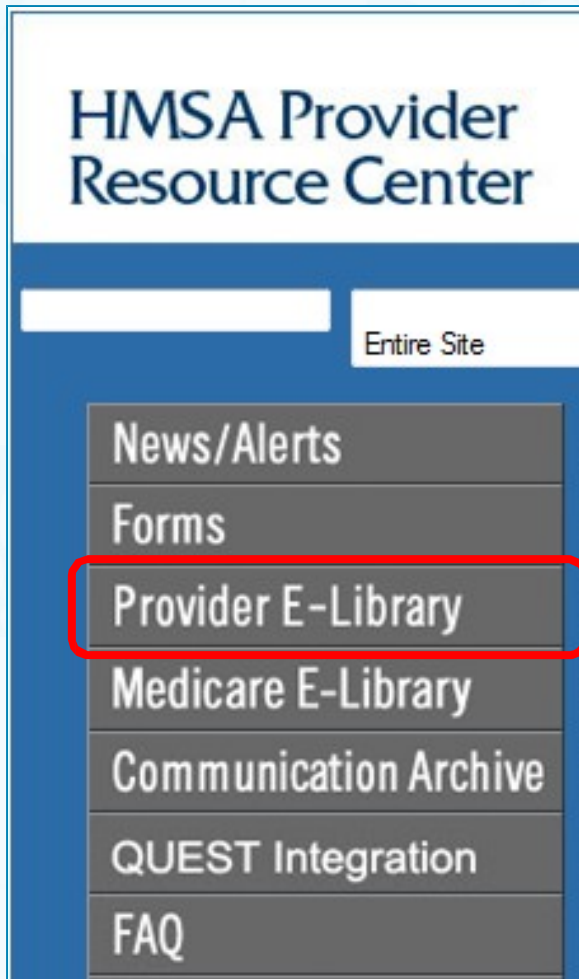
November 2020

*As of 01/01/20, medical claims filed by dentists who are non-contracted with HMSA Medical will be paid at the non par fee. For more information on becoming par Medical, please contact your Provider Network Manager by emailing DentalProviderRelations@bshi.net.

Agenda

- HMSA's Provider Resource Center
- HHIN for eligibility under medical plan
- Claims filing information
- Claims filing tips
- Returned claims
- HMO Plans
- Where to mail paper claims
- Filing claims electronically
- Contact Information

HMSA's Provider Resource Center



- <https://hmsa.com/portal/provider/>
(save it as a Bookmark!)
- Dental providers can access HMSA Medical plan information
- Works best with Internet Explorer browser
- Not necessary to log in

HHIN

Hawaii Healthcare Information Network

- HMSA's website for participating providers to access member plan and benefit information 24/7. Some of the transactions available on HHIN include:
 - Eligibility Verification
 - Plan Benefits
 - Claim Status
- <https://hhin.hmsa.com/HHIN/>
- Access to the secure website is by assigned username and password

HHIN Contacts

- To Request HHIN Access or Training
 - **HHIN Outreach**
 - Phone: (808) 948-6255
 - Email: ETSO outreach@hmsa.com
- For HHIN support (password reset, technical problems)
 - **HHIN Help Desk**
 - Phone: 948-6446 on Oahu or 1 (800) 760-4672 toll free for Neighbor Islands
 - Email: hhinhelpdesk@hmsa.com

CMS 1500 (02-12) claim form (top)



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

Cyan indicates a Required field that must be completed. Otherwise, claim processing may be delayed or the claim may be returned to the provider.
Green indicates a Conditionally Required field that must be completed when a particular condition is present. Otherwise, claim processing may be delayed or the claim may be returned to the provider.
Yellow indicates an Optional field; information is helpful, but not necessary.
Grey indicates an N/A field that is Not Applicable to HMSA claims processing.
 * Asterisk indicates a field for which input error is relatively frequent. Take extra care when completing the field.

PICA				PICA			
1. <input type="checkbox"/> MEDICARE (Medicare#)	<input type="checkbox"/> MEDICAID (Medicaid#)	<input type="checkbox"/> TRICARE (ID#/DoD#)	<input type="checkbox"/> CHAMPVA (Member ID#)	<input type="checkbox"/> GROUP HEALTH PLAN (ID#)	<input type="checkbox"/> FECA BLK LUNG (ID#)	<input type="checkbox"/> OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE MM DD YY		SEX M <input type="checkbox"/> F <input type="checkbox"/>	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>		7. INSURED'S ADDRESS (No., Street)	
CITY				STATE		CITY	
ZIP CODE				TELEPHONE (Include Area Code)		ZIP CODE	
TELEPHONE (Include Area Code)				8. RESERVED FOR NUCC USE		STATE	
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER	
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous) YES <input type="checkbox"/> NO <input type="checkbox"/>		a. INSURED'S DATE OF BIRTH MM DD YY	
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		SEX M <input type="checkbox"/> F <input type="checkbox"/>	
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		b. OTHER CLAIM ID (Designated by NUCC)	
d. INSURANCE PLAN NAME OR PROGRAM NAME				10d. CLAIM CODES (Designated by NUCC)		c. INSURANCE PLAN NAME OR PROGRAM NAME	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a, and 9d.	
SIGNED _____				DATE _____		SIGNED _____	

CARRIER
PATIENT AND INSURED INFORMATION

CMS 1500 (02-12) claim form (bottom)

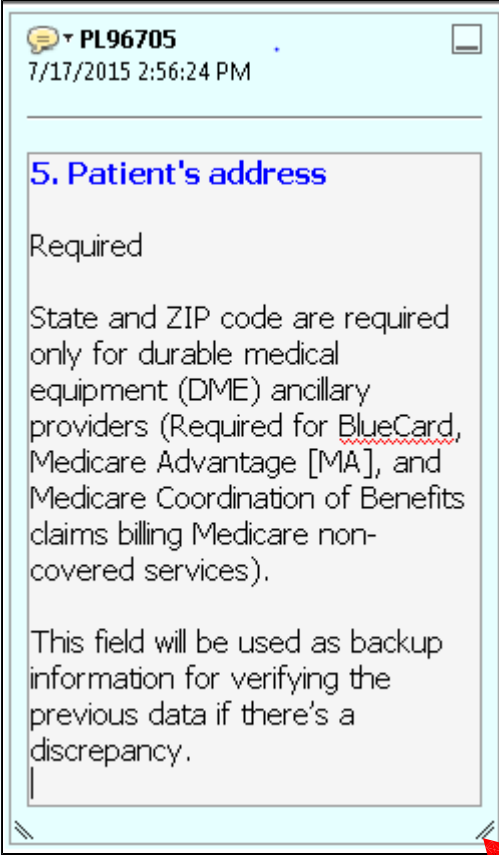
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE QUAL. MM DD YY										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																																																																																									
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																																																																																									
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)																																																																																																													
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) A. B. C. D. E. F. G. H. I. J. K. L.										22. RESUBMISSION CODE ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																																																																																									
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY										B. PLACE OF SERVICE										C. EMG										D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER										E. DIAGNOSIS POINTER										F. \$ CHARGES										G. DAYS OR UNITS										H. ICD-10-PCS										I. ID. QUAL.										J. RENDERING PROVIDER ID. #																			
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25. FEDERAL TAX I.D. NUMBER										SSN EIN										26. PATIENT'S ACCOUNT NO.										27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO										28. TOTAL CHARGE \$										29. AMOUNT PAID \$										30. Hsrd for NUCC Use																																																	
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)										32. SERVICE FACILITY LOCATION INFORMATION										33. BILLING PROVIDER INFO & PH #																																																																																									
SIGNED										DATE										a. NPI										b. NPI										c. NPI										d. NPI																																																											

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE APPROVED OMB-0938-1197 FORM 1500 (02-12)

PHYSICIAN OR SUPPLIER INFORMATION

Using the Interactive Claim Form Tool

- Using the latest version of **Internet Explorer** browser, access the tool at https://hmsa.com/portal/provider/cms1500_interactive_02_12.pdf
- The tool provides detailed instructions on what needs to be placed in each block
- Place your mouse pointer over the **block number** you wish to view
- **Left Click** to display instructions for that block
- If you can't see the entire note, **left click and drag** a corner of the note to resize the window



The screenshot shows a web browser window with the title bar 'PL96705' and the timestamp '7/17/2015 2:56:24 PM'. The main content area is titled '5. Patient's address' in blue text. Below the title, it says 'Required'. The text continues: 'State and ZIP code are required only for durable medical equipment (DME) ancillary providers (Required for BlueCard, Medicare Advantage [MA], and Medicare Coordination of Benefits claims billing Medicare non-covered services)'. Below this, it says: 'This field will be used as backup information for verifying the previous data if there's a discrepancy.' A red arrow points to the bottom-right corner of the form area, indicating where to click and drag to resize the window.

Claim filing tips

- Always use an original “red line” current claim form purchased from form vendors. Photocopies may not be used for original claim submissions
- Use dark ink. Replace printer cartridges or toner when the type begins to fade
- Don’t use highlighters or “white out” on the claim form. This negatively affects the claim scanning process
- Check to make sure all **Required** and **Conditional** blocks are completed

Claim filing tips (cont.)

- Double check for the following for accuracy:
 - Member ID
 - Procedure codes (CPT)
 - Diagnosis codes (ICD-10)
 - Provider ID in Block 33.b
 - Claim form is signed
- Filing deadline is one year from the date of service

Claim filing tips (cont.)

- Block 17 – Name of referring provider - Identify the **type of provider** to the left of the vertical dotted line.
 - DN – Referring provider
 - DK – Ordering Provider
 - DQ – Supervising Provider

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE		17a.	
DN	Clark Mott Jones	17b. NPI	1115557779

Diagnosis Codes

- CMS has a ICD-10 tool that uses keyword search:
<http://www.cms.gov/medicare-coverage-database/staticpages/icd-10-code-lookup.aspx>
- Block 21 – In addition to the ICD diagnosis code, enter the applicable **ICD indicator** to identify which version of ICD codes you're reporting. If the ICD indicator isn't entered, the claim will reject.
 - “o” for ICD-10-CM

21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)				ICD Ind.			
A.		B.		C.		D.	
E.		F.		G.		H.	
I.		J.		K.		L.	

Procedure Codes

- **CPT codes** are used to describe procedures on the CMS-1500. Don't use CDT codes on medical claims.
- Official CPT codebook is published by the American Medical Association
- CPT Procedure codes commonly used by dentists are listed in the Appendix

Procedure Codes

- **IMPORTANT** – Procedures must “point” to the diagnosis or diagnoses relevant to the procedure. Block 24.E. must reference diagnosis line(s) A-L that applies.

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)										ICD Ind.			
A. XXX		B. XXX		C. XXX		D.							
E.		F.		G.		H.							
I.		J.		K.		L.							
24. A. DATE(S) OF SERVICE						B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E. DIAGNOSIS POINTER	
From		To											
MM	DD	YY	MM	DD	YY					CPT/HCPCS		MODIFIER	
													A, B

Returned claims (cont.)

- Claim is returned PRIOR to being processed because of incorrect or missing information
 - Claim does not appear on Report to Provider because it did not get processed
 - Make correction(s) and submit as an initial claim
 - Claim is returned to the provider along with a **Rejection Letter**

Rejection letter – Form 97 (top)



DATE

UNABLE TO PROCESS CLAIM

PROVIDER NAME

ADDRESS

CITY, STATE, ZIP

Thank you for your claims submission on behalf of our member. HMSA is unable to process your claim due to missing or incorrect information as identified below.

HMSA Received Date: 2/1/2015

Service Date(s): 1/1/2015

DCN: A12345678901

Your Patient Control Number: 123456789

Patient Name: Name Here

Total Charge: \$100.00

The above information provided will allow you to view the submitted claim in your system.



Rejection letter – Form 97 (bottom)

Message(s):

- **Error message displayed here**
- **Message requesting additional information displayed here**

Submit a new claim to HMSA with all corrections and changes incorporated into the new claim. To prevent scanning errors, please do not use red ink, or scratch or white out fields on returned claims.

To submit a new hardcopy claim, send the new CMS claim to: HMSA Claims, P.O. Box 44500, Honolulu, HI. 96804-4500. Send the new UB claim to: HMSA Claims, P.O. Box 32700, Honolulu, HI. 96803-2700.

If you submit claims electronically you may submit a corrected claim electronically. If you currently submit paper claims to HMSA, ask us about our electronic solution that can benefit your office. Please contact our Electronic Transaction Services staff at 808-948-6355 on Oahu or toll free at 1-800-377-4672.

If you have any questions please contact HMSA's Customer Relations office at 948-6330 or neighbor islands 1-800-790-4672. Please provide them with the internal reference number at the bottom of this letter.

CA/MR HM 00001

Internal Reference Number: N0000123456

Returned claims (cont.)

- Claim needs additional information
 - Claim is denied on the Report to Provider as requesting additional information (e.g. operative notes, primary carrier EOB)
 - See instructions for **Resubmitting Claims**

Resubmitting Claims

- Resubmitted claims require the following:

Requirement	CMS-1500
Indication of replacement claim	Block 22 – Resubmission code “7” – (Replacement)
Original HMSA Claim ID	Block 22 – Original Ref. No. must contain Original HMSA Claim ID
Reason for correction	Block 19 – Reserved For Local Use Include text explaining reason for attachments (e.g. op notes, EOB)

- Claims without this information will deny as a duplicate claim
- Remember to include any necessary attachments with the resubmitted claim




Following up on claims

- The following webpage contains links to:
 - Verify Claim Status
 - Follow up on denied claims
 - Information on Coordination of Benefits (COB) between two health plans
 - Information on Claim Reconsideration Requests

http://www.hmsa.com/portal/provider/zav_pel.aa.res.600.htm

HMO Plans

- HMSA HMO plans require a referral from the patient's PCP to a dentist for non-urgent, non-emergent medical services
 - The medical coverage information is usually alpha
 - The patient's PCP is listed on their HMSA membership card

HMSA 	
Subscriber Name HMO P CARRIER 3990	Group 9391
	
Subscriber ID XLAR000090000019	
MAUI MEDICAL GROUP PLEASE CALL TO SELECT A PCP	MEDICAL A-A VISION 00R
PCP's name appears here	DRUG 355 RXBIN 004336 RXPCN ADV RXGRP RX3990
	

HMO Plans (cont.)

- **Participating dentists** must contact the patient's PCP prior to rendering services to make them aware that the patient needs services. If the PCP approves the referral, they will note it in their patient's medical record. The dentist also makes a note in their patient's chart that the PCP referred the patient. The PCP does not need to send a written referral to the dentist, and the dentist does not need to submit a written referral with the claim.
- Claims for referred HMO patients must include the name of the referring PCP, Type of Provider, and NPI in Block 17 on the CMS-1500. Name format: First Middle Last

HMO Plans (cont.)

- **Non-Participating dentists** must contact the patient's PCP prior to rendering services to make them aware that the patient needs services. They need to inform the PCP that they are non-participating with HMSA. Services rendered to HMSA's HMO members by non-participating providers are not eligible for benefit coverage unless HMSA has authorized the services through HMSA's Administrative Review process prior to services being rendered. The PCP is responsible for requesting the Administrative Review from HMSA. HMSA sends the determination letter to the PCP, patient, and servicing provider.

Electronic Transactions

EDI (Electronic Data Interchange). A communication system that allows the electronic exchange of data between business partners.

HMSA supports the following EDI transactions:

- Electronic Claims Submission (837)
- Electronic Eligibility Verification (270, 271)
- Electronic Claim status (276)
- Electronic Remittance Advice (835)
- Electronic Report to Provider (eRTP)
- Electronic Funds Transfer (EFT)

How to start filing claims electronically

- Call the EDI Help Desk
 - Phone: 948-6355 on Oahu or 1 (800) 377-4672 toll-free for Neighbor Islands
 - Fax: All islands – 1 (808) 948-6008

Where to mail CMS 1500 claims

- **Commercial (PPO, HMO, Akamai Advantage)**

HMSA – CMS 1500 Claims

P.O. Box 44500

Honolulu, HI 96804-4500

- **BlueCard (Out of State Blue Cross Blue Shield members)**

HMSA – BlueCard Program

P.O. Box 2970

Honolulu, HI 96802

- **QUEST Integration**

HMSA QUEST Integration

P.O. Box 3520

Honolulu, HI 96811-3520

Contact information

Questions on claim denials, HMSA medical policies,
plan benefits

Plan	Oahu	Neighbor Island (toll free)
PPO, HMO	948-6330	1-800-790-4672
BlueCard	948-6280	1-800-648-3190
QUEST Integration	948-6486	1-800-440-0640

Mahalo!

Your hard work
makes us
SMILE!



Appendix

CDT Code	Description of CDT Code	CPT Code	Description of CPT Code
D7260	Oroantral fistual closure	30580	Repair fistula; oromaxillary
D7285	Biopsy of oral tissue (hard)	20220	Biopsy, muscle; superficial
		20240	Biopsy, bone, open; superficial (ilium, sternum, spinous process, ribs, trochanter or femur)
		20245	Biopsy, bone, open; deep (eg humerus, ischium, femur)
D7286	Biopsy of oral tissue (soft)	20220	Biopsy, muscle; superficial
		20205	Biopsy, muscle; deep
		40490	Biopsy of lip
		40808	Biopsy, vestibule of mouth
		41100	Biopsy of tongue; anterior 2/3
		41105	Biopsy of tongue; postterior 1/3
		41108	Biopsy of floor of mouth
		42100	Biopsy of palate, uvula
		42800	Biopsy, oropharynx
D7410	Exc benign les; up to 1.25 cm	21030	Exc benign tumor or cyst of maxilla or zygoma by enucleation & curettage
		21040	Exc benign tumor or cyst of mandible by enucleation & curettage
		41825	Exc of les or tumor, dentoaveolar structures; without repair
		41826	Exc of les or tumor, dentoaveolar structures; with simple repair
		41827	Exc of les or tumor, dentoaveolar structures; with complex repair
D7411	Exc of benign les; > 1.25 cm	21030	Exc benign tumor or cyst of maxilla or zygoma by enucleation & curettage
		21040	Exc benign tumor or cyst of mandible by enucleation & curettage
		41825	Exc of les or tumor, dentoaveolar structures; without repair
		41826	Exc of les or tumor, dentoaveolar structures; with simple repair
		41827	Exc of les or tumor, dentoaveolar structures; with complex repair
D7412	Exc of benign les; complicated	21030	Exc benign tumor or cyst of maxilla or zygoma by enucleation & curettage
		21040	Exc benign tumor or cyst of mandible by enucleation & curettage

Appendix (cont.)

CDT Code	Description of CDT Code	CPT Code	Description of CPT Code
D7413	Exc of malig les up to 1.25 cm	41827	Exc of les or tumor, dentoalveolar structures; with complex repair
		21034	Exc of malig tumor of maxilla or
		21044	Exc of malig tumor of mandible
D7414	Exc of malig les > 1.25 cm	21034	Exc of malig tumor of maxilla or
		21044	Exc of malig tumor of mandible
D7415	Exc of malig les; complicated	21034	Exc of malig tumor of maxilla or
		21044	Exc of malig tumor of mandible
		21045	Exc of malig tumor or mandible; radical resection
D7440	Exc of malig tumor; les < 1.25 cm	21034	Exc of malig tumor of maxilla or
		21044	Exc of malig tumor of mandible
		21045	Exc of malig tumor or mandible; radical resection
D7441	Exc of malig tumor; les > 1.25 cm	21034	Exc of malig tumor of maxilla or
		21044	Exc of malig tumor of mandible
		21045	Exc of malig tumor or mandible; radical resection
D7460	Removal of benign nonodontogenic cyst or tumor; les < 1.25 cm	21030	Exc benign tumor or cyst of maxilla or zygoma by enucleation & curettage
		21040	Exc benign tumor or cyst of mandible by enucleation & curettage
		41825	Exc of les or tumor, dentoalveolar structures; without repair
		41826	Exc of les or tumor, dentoalveolar structures; with simple repair
		41827	Exc of les or tumor, dentoalveolar structures; with complex repair
D7461	Rem of benign nonodontogenic cyst or tumor; les > 1.25 cm	21030	Exc benign tumor or cyst of maxilla or zygoma by enucleation & curettage
		21040	Exc benign tumor or cyst of mandible by enucleation & curettage
		41825	Exc of les or tumor, dentoalveolar structures; without repair
		41826	Exc of les or tumor, dentoalveolar structures; with simple repair
		41827	Exc of les or tumor, dentoalveolar structures; with complex repair
D7520	Incision & drainage of abscess - extraoral soft tissue	10060	I & D of abscess (eg carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); simple or single
		10180	I & D, complex, postoperative wound infection

Appendix (cont.)

CDT Code	Description of CDT Code	CPT Code	Description of CPT Code
		41015	Extraoral I & D of abscess, cyst, or hematoma of floor of mouth;
		41016	Extraoral I & D of abscess, cyst, or hematoma of floor of mouth;
		41017	Extraoral I & D of abscess, cyst, or hematoma of floor of mouth; submandibular
		41018	Extraoral I & D of abscess, cyst, or hematoma of floor of mouth;
		42300	Drainage of abscess; parotid simple
D7521	Incision & drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	10061	I & D of abscess (eg carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia); complicated or
		42320	Drainage of abscess; submaxillary,
		42305	Drainage of abscess; parotid,
D7910	Suture of recent small wounds up to 5 cm	12011	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes < 2.5 cm
		12013	Simple repair of superficial wounds of face, ears, eyelids, nose, lips, and/or mucous membranes 2.6 to 5.0 cm
		12051	Repair, intermediate wounds of face, ears, eyelids, nose, lips and/or mucous membranes 2.6 to 5.0 cm
		12052	Repair, intermediate wounds of face, ears, eyelids, nose, lips and/or mucous membranes 2.5 cm or less
		40830	Closure of laceration, vestibule of mouth, 2.5 cm or less
		41250	Repair of laceration 2.5 cm or less; floor of mouth and/or anterior 2/3 of tongue
		41251	Repair of laceration 2.5 cm or less; floor of mouth and/or posterior 1/3 of tongue
		42180	Repair of laceration of palate up to 2 cm

Disclaimer

Use of CDT to CPT Crosswalk codes on CMS 1500 claims does not guarantee payment and providers are advised to contact the member's medical insurance for verification of eligibility and benefits.